Report of the Task Force on Quality of Care in Maryland Nursing Facilities

December 1999

Parris N. Glendening
Governor

MARYLAND DEPARTMENT OF Aging

Sue Fryer Ward
Secretary

301 West Preston Street, Suite 1007 • Baltimore, Maryland 21201-2374
410-767-1100 • FAX 410-333-7943 • 1-800-AGE-DIAL (1-800-243-3425) • TTY 410-767-1083

December 23, 1999

The Honorable Parris N. Glendening
Governor
State House
Annapolis, Maryland

Dear Governor:

As required by Chapters 382 and 383 of the Laws of Maryland of 1999, I submit the report of the *Task Force on Quality of Care in Nursing Homes*. The Task Force was charged to study the quality of care in Maryland nursing facilities, including: standards; staffing patterns; the labor pool available to fill nursing jobs; and findings of the General Accounting Office report on nursing home complaints. Based on its findings, the Task Force was directed to recommend changes necessary to ensure quality of care, including, if needed, appropriate levels of staffing and changes to funding mechanisms.

This document reports the findings and recommendations of the Task Force and explains how the recommendations were developed. At this time, let me extend sincere appreciation to members of the Task Force who labored long and hard to accomplish its mandate. Meetings began in early July, 1999 and were necessary beyond the December 1 deadline set in legislation. In addition to the involvement of Task Force members, two workgroups were created to address issues of concern. Membership in the workgroups included representatives of the nursing home industry, unions, health, social, and legal communities. On behalf of the Task Force, thanks to these dedicated individuals as well. The Task Force also conducted five public hearings across the State to obtain input from the public at large and we appreciate the many citizens, both professionals and family members for their important contributions.

The quality of care in Maryland nursing homes is in need of immediate government attention. A substantial investment of both financial and human resources over the long term will be required to realize changes needed today. It is my hope that recommendations contained in this report will receive your support as well as that of the General Assembly.

It has been a privilege to serve as Chair of the *Task Force on Quality of Care in Nursing Homes* and I look forward to working with you and the legislature to act upon the recommendations it developed.

Sincerely,

Sue F. Ward
Chair

cc: The Honorable T. V. Mike Miller, President of the Senate
The Honorable Casper R. Taylor, Jr., Speaker of the House

TASK FORCE ON QUALITY OF CARE IN NURSING HOMES

MEMBERS

Sue Fryer Ward, Chair
Secretary, Maryland Department of Aging

Senator Michael J. Collins - District 6
Senator Arthur Dorman - District 21
Senator Paula C. Hollinger - District 11
Senator Leonard H. Teitelbaum - District 19

Delegate Charles R. Boutin - District 34
Delegate Peter A. Hammen - District 46
Delegate Katherine Klausmeier - District 8
Delegate Shirley Nathan-Pulliam - District 10

Elizabeth Boehner, Director
Montgomery County Division of Aging Services

Margaret Bradford, Director
MAC Area Agency on Aging

Charles Fisher, Director
Baltimore County Department of Aging

Carol Benner, Director
Office of Health Care Quality
Maryland Department of Health and Mental Hygiene

STAFF TO THE TASK FORCE

Michael Lachance, Legislative Liaison
Maryland Department of Aging

Stephanie Garrity, Chief, Client and Community Services
Maryland Department of Aging

Joanne Keiser, Program Manager
Maryland Department of Aging

James Macgill, Deputy Secretary
Maryland Department of Aging

TABLE OF CONTENTS

Executive Summary

Senate Bill 740 and House Bill 791, passed in the 1999 General Assembly, required the creation of a Task Force on Quality of Care in Nursing Facilities. The Nursing Home Task Force, as it will be referred to in this report, was charged to study the quality of care in Maryland nursing facilities. The scope of the study was to include an examination of current quality of care standards for nursing facilities, staffing patterns and standards, and the status of the labor pool available to fill nursing jobs. Based on the findings, the legislation required the Task Force to recommend changes to current standards, policies, and procedures necessary to ensure quality of care in nursing facilities; if necessary, a methodology for determining appropriate levels of staffing and standards; and if necessary, changes to funding mechanisms.

The Task Force was authorized as the result of two developments: growing recognition that nursing homes were severely understaffed, and issues raised by the federal General Accounting Office (GAO). The GAO criticized Maryland's regulatory oversight of the nursing home industry in a report issued in March 1999.

The Task Force conducted its work from July to December 1999. It received input from two workgroups consisting of representatives from the industry, the Service Employees International Union, State and local agencies, professional organizations, advocacy groups, and consumers. It held nine meetings in Annapolis, and conducted five public forums, covering all areas of the state.

The Task Force made ten findings as a result of its process as follows:

1) Nursing home residents have more complex and acute medical needs than in previous decades.

2) Personal care needs of residents are not being met. There has been a decline in the quality of care in Maryland's nursing homes.

3) Nursing Assistants, who provide most of the care in the homes, are in positions with little mobility, limited opportunity, and poor pay. The result is large turnover in these positions and continued staff shortages.

4) The Balanced Budget Act of 1997 reduced Federal reimbursement to nursing homes.

5) The 1998 Federal Nursing Home Initiatives (NHIs) have had a major resource impact on Maryland's regulatory system, managed by the Department of Health and Mental Hygiene's Office of Health Care Quality (OHCQ). This impact is compounded by OHCQ's difficulty in recruiting qualified survey staff.

6) In response to the GAO report and new directives from HCFA, OHCQ has made complaint investigation a higher priority.

7) State licensure laws for enforcing action against nursing homes with poor quality of care are not effective. These laws do not lead to early intervention and the encouragement of nursing homes to achieve and maintain compliance with standards. At present, enforcement action for nursing homes with poor quality is dependent on federal regulations.

8) Maryland nursing homes are not practicing internal health quality assurance and as a result are less proactive in dealing with quality issues.

9) Advocacy efforts on behalf of nursing home residents are underfunded and need to be strengthened. In particular, the Long Term Care Ombudsman program does not have the resources to do its job.

10) Family Councils can be a valuable source of advocacy for residents, provided that they operate independently of nursing home administration.

Based on these findings, the Task Force is making a series of recommendations. The most significant of these recommendations are as follows:

1) Continue the Task Force as an oversight committee to monitor progress on the implementation of its recommendations.

2) Increase minimum staffing standards for resident care in nursing homes to four hours per resident per day, with unlicenced direct care staffing set at a minimum of three hours per resident per day. This recommendation includes a sub recommendation to establish a Medicaid financed wage-pass through, designed to increase nurse aide hourly wages by $2.00 per hour. Financing the whole recommendation will require an increase of 98.6 million in the State Medicaid Budget.

3) Improve the quality of the nursing home workforce.

4) Strengthen State regulation of nursing homes.

5) Improve quality assurance programs in nursing homes.

6) Strengthen consumer advocacy, including the long term care ombudsman program. Financing the whole recommendation will require an increase in the State General Fund Budget of 1.9 million.

SECTION 1 THE CHARGE TO THE TASK FORCE (FROM SB 740, HB 791)

Senate Bill 740 and House Bill 791, passed in the 1999 General Assembly, required the creation of a Task Force on Quality of Care in Nursing Facilities. The Bill specified that the Task Force would consist of two members of the Senate Finance Committee, appointed by the President of the Senate; two members of the Senate Economic and Environmental Affairs Committee, appointed by the President of the Senate, four members of the House Environmental Matters Committee, appointed by the Speaker of the House, the Secretary of the Department of Aging, the Secretary of the Department of Health and Mental Hygiene, or the Secretary's designee; and three representatives of area agencies on aging, appointed by the Secretary of Aging. The Secretary of Aging was designated as the Chair of the Task Force.

The Task Force was charged to study the quality of care in Maryland nursing facilities. The scope of the study was to include an examination of current quality of care standards for nursing facilities, staffing patterns and standards, and the status of the labor pool available to fill nursing jobs. The Task Force was also to review the findings of a March 1999 U.S. General Accounting Office report on nursing home complaints to the Special Committee on Aging of the U.S. Senate, and Maryland's policies and procedures for inspecting nursing facilities and responding to quality of care complaints. The Task Force was instructed to make a comparison of the Maryland standards, policies, and procedures to those in other states, and to examine State funding mechanisms for, and regulation of nursing facilities.

Based on the findings, the legislation required the Task Force to recommend:

- changes to current standards, policies, and procedures necessary to ensure quality of care in nursing facilities;
- if necessary, a methodology for determining appropriate levels of staffing and standards; and
- if necessary, changes to funding mechanisms.

SECTION 2 BACKGROUND: THE NURSING HOME INDUSTRY IN MARYLAND AND HOW IT IS REGULATED

A) An Overview of the Nursing Home Industry in Maryland

Sources: American Health Care Association and Maryland Department of Health and Mental Hygiene

In 1997, an estimated 26,286 persons received care in Maryland nursing facilities. As of 1998, there were 261 nursing facilities in Maryland with 31,562 beds. These broke down by primary payer source as follows:

Medicare only	851
Medicaid only	16,785
Medicare/Medicaid dually certified	12,242
Not certified for Medicare or Medicaid	1,684
Total	31,562

Maryland nursing home residents needed, on average, assistance with 3.94 Activities of Daily Living (ADLs), compared with a national average of 3.67. Maryland ranks in the top seven of States and the District of Columbia on this ADL measure, indicating that nursing home residents in Maryland are more disabled and need more assistance from nursing assistants than residents in most other states.

The average bed capacity for nursing homes in Maryland is 125, compared with a national average of 107. Maryland nursing homes rank in the top six of States and the District of Columbia in average bed capacity. Forty-five percent (45%) of Maryland nursing facilities are part of a chain. "Chain" facilities are those which are owned or leased by a multi-facility organization. The other 55% are independently operated entities. Additionally, 57.3% of Maryland's facilities are for profit, 39.5% are not for profit, and 3.2% are government controlled. Thirteen percent (13%) are hospital-based Skilled Nursing Facilities.

The average total direct care staff per facility for nursing homes in Maryland is 72, including 47 certified nurse assistants (CNAs), 14 licensed practical nurses (LPNs), and 12 registered nurses (RNs). The equivalent national figures are 55 total direct care staff, composed of 37 CNAs, 12 LPNs, and 7 RNs.

There are 2,450 special care beds in Maryland, distributed as follows:

1,539 Alzheimer beds;
173 AIDS beds;
158 ventilator beds;
524 special rehabilitation beds ;
22 hospice beds; and
34 other special care beds.

B) Regulatory Oversight of the Maryland Nursing Home Industry

(Source: Department of Health and Mental Hygiene)

In Maryland, the principal regulatory agency of the nursing home industry is the Office of Health Care Quality (OHCQ), formerly the Licensing and Certification Administration. OHCQ is an administration of the Department of Health and Mental Hygiene. The mission of the Office is as follows:

- to develop standards for quality care in all Maryland health care facilities and community residential programs;
- to protect Maryland citizens in health care facilities and community residential programs through regulation and enforcement;
- to educate consumers and providers on standards and quality issues;
- to respond to the public concerning quality of care complaints or inquiries;
- to improve quality of care.

OHCQ's principal interaction with nursing homes comes in the form of surveys and inspections to determine compliance with State and federal regulations. Federal law requires each Medicare and Medicaid certified nursing home to be surveyed at least every nine to fifteen months and requires the State to have an overall twelve-month average. Nursing home surveyors go through a six-to-nine month orientation and then must pass a federal test before they can conduct surveys. Orientation and training of nursing home surveyors generally take twelve to eighteen months.

In Maryland, a survey team for a 150_bed nursing home with an average performance record will consist of a team of two or three nurses, a dietitian and a sanitarian. The Health Care Financing Administration (HCFA), the federal agency that is responsible for nursing home oversight, reports that surveys in Maryland take an average of 140 surveyor hours compared to a national average of 160 hours. All surveys are unannounced. Surveyors review charts, observe care, and interview both staff and residents. Regulations are outcome-based; deficiency statements reflect what has actually happened or could happen to a resident because of the care he or she did or did not receive.

HCFA contracts with and pays the State to carry out survey and certification work for Medicaid and Medicare certified facilities. To receive funding from HCFA, the State must document that the work has actually been completed. Overall, the budget for these licensure and certification functions is financed approximately 50/50 between State and federal funds. Annually, HCFA asks the State to estimate the amount of funding it will require to conduct the federal work. Based on this estimate and the Congressional allocation for the entire country, HCFA will cap the State at the amount of funding it can receive.

In addition, if HCFA does not believe the State is performing satisfactorily, or if the State does not follow HCFA's rules, it can withhold funds from the State. HCFA can cap the amount of reimbursement the State can receive or can impose other sanctions.

Since 1995, every deficiency identified in a nursing home by OHCQ is assigned a severity and scope rating on a HCFA-developed grid. Sanctions are dependent on the level of deficiency that is identified.

	Isolated	*Pattern*	*Widespread*
Serious and immediate	*J*	*K*	*L*
Actual harm	*G*	*H*	*I*
Potential for harm	*D*	*E*	*F*
No harm	*A*	*B*	*C*

Following are examples of deficiencies and the codes they receive on the grid:

D - A resident with high blood pressure is given too much medicine, with no resulting harm. A resident's blood sugar is very low and no one contacts the doctor, with no resulting harm. Nursing home staff throw away medical waste inappropriately.

G - A resident is not properly turned or positioned and develops a bedsore. A resident does not receive sufficient fluids and is taken to the hospital with dehydration. A resident with diabetes is not given insulin and goes into a coma.

H - Several residents with non-healing bedsores have significant weight losses. Residents who have a history of falling are unsupervised, have not received proper assessments and continue to fall and suffer injuries.

J - A resident with an inappropriately applied restraint is strangled to death.

If a D, E, or F level deficiency is found on an initial survey, the State can accept a written plan of correction as evidence of compliance. If a G or higher level deficiency is found on the initial survey, the nursing home is given an opportunity to correct its problems. The State will verify corrective action with a revisit. At the revisit, the home must demonstrate substantial compliance (no deficiencies above a C level). If the nursing home fails the second survey, the State gives the nursing home a second opportunity to correct. If the nursing home fails this visit, HCFA must give the State permission to conduct an additional survey.

Below is a chart showing how the enforcement process works with respect to deficiencies:

Enforcement Process

Initial Visit	First ---- Revisit -----		Second ---- Revisit -----	
Day 1	60	90	180	210
		If a deficiency >C is found, there is an automatic ban on payment	If a deficiency >C is found, there is an automatic termination and relocation	

States have a variety of federal sanctions that can be used within the 180-day period to encourage compliance. These include fines, directed plans of correction, and temporary management. Termination or loss of funding from the Medicare and Medicaid Programs is the sanction of last resort. Since 1995, Maryland has levied more than $800,000 in fines against nursing homes; however, less than 200,000 dollars has actually been collected.

In July 1998 President Clinton announced several new initiatives that would strengthen enforcement of nursing home standards. These included staggered surveys on weekends and off-hours, mandatory revisits for all "G" level deficiencies, and termination from the Medicare and Medicaid Programs for noncompliance after 180 days. As these initiatives were implemented, the number of deficiencies identified in Maryland nursing homes began to rise. The following Table shows the types and numbers of sanctions that the State imposed in FY98, FY 99, and the first quarter of FY 2000.

Action Taken by State	7/1/97 - 6/30/98	7/1/98/ - 6/30/99	7/1/99- 9/30/99
Fines	3	11	4
Denial of Payment for New Admissions	2	8	2
Prohibition from Offering a Nurse Aide Training Program	6	17	4
Mandated Staffing Pattern	2	18	2
Termination from Medicare and Medicaid	2	9	1

The federal Nursing Home Initiative has also had a major impact on OHQA operations. The increase in deficiencies has generated a dramatic increase in follow-up surveys, from 62 in FY 98 to 169 in FY 99, an increase of 273%. Meanwhile, OHQA has been unable to keep up its schedule of regular annual surveys, which decreased from 252 in FY 98 to 210 in FY 99.

OHCQ also investigates consumer complaints. Prior to March 1999, HCFA required States to investigate all complaints that alleged a serious and immediate threat to resident safety within two working days and all others at least by the next survey. In March 1999, this directive was changed to require any allegation of actual harm to be investigated within ten working days.

SECTION 3 BACKGROUND OF THE LEGISLATION

Senate Bill 740/HB 790 contained a number of provisions aimed at improving quality of nursing home care in Maryland, including reform of Medicaid's reserve bed payment policy and establishment of a nursing home report card. Authority for The Nursing Home Task Force, was added to the legislation as the result of two developments: growing recognition that nursing homes were severely understaffed, and issues raised by the federal General Accounting Office (GAO), which criticized Maryland's regulatory oversight of the nursing home industry in a report issued in March 1999.

The staffing issue was brought to the General Assembly's attention by the local chapter of Service Employees International Union (SEIU) District 1199 E. The parent union, SEIU has launched a nationwide "Dignity Campaign" to improve working conditions in nursing homes. The campaign includes lobbying state legislatures for increased staffing levels and reimbursement

rates, negotiating improved wages and benefits packages for workers and forming coalitions with advocates to bring about nursing home reform. The SEIU is concerned that staffing shortages are linked to a decline in quality of care for nursing home residents, resulting in serious medical problems such as bed sores, malnutrition, and contractures for the residents. In addition, the Union notes an increase in the illness and injury rate for nursing home workers, particularly back injuries arising from lifting and moving patients.

The GAO report was one of a series of reports prepared by the agency at the request of the Special Committee on Aging of the United States Senate, evaluating nursing home care and its regulation by the states, and HCFA's role in overseeing that regulation. The GAO concluded that there were serious deficiencies in public oversight of nursing homes resulting in appalling conditions, and life-threatening situations for residents.

In a report dated March 18, 1999, the GAO stated that "surveys conducted in the nation's 17,000-plus nursing homes in recent years showed that each year, more than one-fourth of the homes had deficiencies that caused actual harm to residents or placed them at risk of death or serious injury. The most frequent violations causing actual harm included inadequate prevention of pressure sores, failure to prevent accidents, and failure to assess residents' needs and provide appropriate care."

In a report dated March 22, 1999, the GAO reported on State practices for investigating of nursing home complaints. The GAO conducted its own review in Maryland, Michigan, and Washington and reported on internal audits in 11 other states. It also reviewed HCFA policies for directing State complaint activities.

The overall conclusion by the GAO was that "Federal and states' practices for investigating complaints about care provided in nursing homes are often not as effective as they should be." In their study, the GAO auditors identified a number of problems including "procedures or practices that may limit the filing of complaints, understatement of the seriousness of complaints, and failure to investigate serious complaints promptly." The GAO charged that "serious complaints alleging that nursing home residents are being harmed can remain uninvestigated for weeks or months. Such delays can prolong situations in which residents may be subject to abuse, neglect resulting in serious care problems like malnutrition and dehydration, preventable accidents, and medication errors."

Some key findings regarding Maryland were as follows:

- Maryland tends to assign complaint investigations a lower priority than other states. Nationally, states spend 20% of their survey and certification budgets on complaint investigations. Maryland spends 8%. In Fiscal Year 1998, Maryland made 6.5 complaint visits per 1000 beds, compared with a national ratio of 23.7.

- The GAO believes that Maryland's practice of encouraging people with complaints to submit them in writing results in limiting the number of complaints.

- Maryland tends to classify complaints in lower priority categories. In FY 98, the GAO stated that "Maryland did not identify a single complaint as potentially representing immediate jeopardy." In addition, the GAO stated that "Maryland placed most complaints in its lowest-priority category to be investigated at the next on-site survey. This contrasts with Washington, which categorized nearly 90 percent of its complaints to be investigated within either two or 10 workdays."

- The GAO found that states in general "often do not conduct investigations of complaints within the time frames they assign.... Some of these complaints, despite alleging serious risk to resident health and safety, remained uninvestigated for several months after the deadline for investigation." The GAO identified four cases from a review of FY 1998 Maryland records where allegations of serious harm to a resident were not investigated promptly. In one case "Resident had caked feces all over his body, dried blood under his fingernails and on his hand, and pressure sores all over his body. A member of the ambulance team that transported the resident to the hospital questioned whether the home properly cared for the resident." The investigation did not begin until 130 days after the allegation was made.

- Maryland had not developed a Quality Improvement Program for measuring performance in complaint investigations in accordance with HCFA requirements.

In responding to the draft, the Licensing and Certification Administration (now the Office of Health Care Quality) stated that Maryland was taking steps to improve the State's complaint process. In 1998, new staff were assigned to the complaint unit, and the survey and complaint units were merged under one administrator. Licensing and Certification noted an improvement in the timeliness of complaint investigations due to these changes. In addition, the Administration criticized the report for its "relatively narrow focus," and its tendency to "target only the complaint process" rather than looking at the total regulatory process. Licensing and Certification concluded that "There exists at present a critical need for additional Federal resources in all facets of the regulatory process."

Concerns about the staffing issue and the GAO report led to the rewrite of Senate Bill 740 and its House Companion Bill 790 and their passage by large margins. The Nursing Home Task Force was charged to investigate quality of care in the homes.

SECTION 4 THE PROCESS USED BY THE TASK FORCE

The Nursing Home Task Force conducted its work from July to December 1999. At the outset, the Task Force determined it was important to hear from all the major stakeholders in quality of care in nursing homes, including the industry, employees, consumers, advocates, regulators, and professional associations. The Task Force took the following steps to assure that these various players would have sufficient opportunity for input into the Task Force's report:

- At its first meeting, the Task Force established two workgroups to study the main issues: a Quality & Practice Workgroup chaired by Dr. Ann Marie Spellbring, and a Consumer Protection & Patient Rights Workgroup chaired by Mr. William Bechill. Both groups included representatives from the industry, the union, appropriate State and local agencies, professional organizations, advocacy groups, and consumers.

- The Task Force invited presentations at its meetings from experts (including HCFA and the GAO) in the area of nursing home care.

- The Task Force agreed to offer an opportunity for public comment at each meeting including workgroup meetings.

- The Task Force conducted five public forums around the State to allow for public comment and suggestions. The forums were held in Baltimore City, Prince Frederick, Gaithersburg, Denton, and Hagerstown.

The Task Force met a total of nine times between July and December, in the House Environmental Matters Committee room in Annapolis. At its final meeting, the Task Force adopted this report and the recommendations it contains.

SECTION 5 FINDINGS

Finding 1: Nursing home residents have more complex and acute medical needs than in previous decades.

Joshua Weiner, a national expert on long term care, with the Urban Institute estimates that the percentage of nursing home residents with problems with three or more Activities of Daily Living (ADLs) increased from 72% in 1987 to 83% in 1996. The American Health Care Association states that the average number of ADL limitations per resident in the U.S. is 3.67, and for Maryland is 3.94.

Several factors contribute to the growth in severely disabled nursing home residents:

The growing number of Marylanders 85 and over. The 85+ population in Maryland is estimated to rise by almost 40% in 2000, compared with 1990. The 85+ population tends to be more disabled, and more likely to be living in nursing homes, than younger cohorts of elderly. According to the federal Administration on Aging, disability increases substantially with age, rising from 3.1 percent for the 65-74 cohort, to 18.1 percent for the 85+ age group. In addition, while only 1.1% of the 65-74 U.S. population lives in nursing homes, 19.8% of the 85+ population does. As the 85+ population grows, nursing homes are seeing the impact; residents are older with more complex health problems than previously.

Earlier discharges from hospitals. The average length of stay in hospitals has declined, both nationally, and in Maryland, as payers put more pressure to move patients to less

expensive forms of care. As a result, nursing home residents tend to have more acute care needs than previously.

Competition from assisted living. As the assisted living industry has grown in Maryland, it is tending to serve less disabled seniors who formerly would have had a nursing home as their only long term care alternative.

Finding 2: Personal care needs of residents are not being met. There has been a decline in the quality of care in Maryland's nursing homes.

As the number of residents with complex medical needs has grown, the need for specialized care has grown as well. In addition, as the acuity of resident care needs increases, the average time needed to care for a resident goes up. This trend puts more pressure on nursing assistants, who provide 85-90% of the direct care of residents. The result is that staff in many facilities are unable to meet the basic medical needs, let alone the personal needs of their residents.

In testimony before the Task Force on July 22, 1999, Certified Geriatric Nursing Assistant Narcissus Jackson testified that she had been responsible for the care of nine residents, five of whom required complete care. Ms. Jackson testified that due to understaffing, she often was unable to take care of basic care needs such as mouth care and incontinent care, feed her residents in a timely manner, or take them to the bathroom when they needed to go. Moreover, she did not have the time to sit and talk with the residents to help overcome loneliness and find out how they were feeling. Ms. Jackson's experience, unfortunately, does not appear to be uncommon.

The General Accounting Office, in its series of reports on the nursing home industry, identified the quality of care problems which result from the deficits in personal care needs. In a presentation before the Task Force on August 26, 1999, Ms. Kathryn G. Allen, Associate Director and Mr. John E. Dicken, Assistant Director of Health Financing and Systems Issues, U. S. General Accounting Office, summarized some of the agency's findings. In a review of California nursing home care, auditors found that "55 percent of medical records reviewed had serious care problems." And "30 percent of homes had deficiencies that caused death or serious harm." Nationwide, the GAO estimated that 27 percent of homes had deficiencies that "caused actual harm or immediate jeopardy." Most frequent deficiencies noted by the GAO, in the period of its nationwide study (January 1997-October 1998) were pressure sores, accidents, resident care and needs, and nutrition.

Inadequate staffing, and resulting lack of attention to personal care needs results in an increase in resident health care problems, including incontinence, pressure ulcers, dehydration and others. Maryland's current standard for direct nursing care staff is that a home must provide 2.0 hours of direct nursing care per day per resident. According to DHMH, on average, Medicaid pays for 3.1 hours per Medicaid resident per day. **Even this higher ratio is not adequate, given the needs of the residents.**

The decline in quality of care is indicated by increased complaints, deficiencies and sanctions. Consistent with national trends reported by the GAO, the OHCQ reported that the number of complaints alleging actual harm to residents has more than doubled. Whereas

consumers used to call with complaints concerning lost property or dentures, complaints now are very sophisticated and articulate poor care. Examples include allegations of residents who are sent to the hospital with dehydration, receive bed sores because of inadequate assessments and care, and injuries resulting from inadequate supervision. It is possible that the number of complaints has increased because of the increased media attention and heightened awareness of consumers.

A more important indicator of diminished quality is the increase in nursing homes with substandard care. From FY98 to FY99 this number tripled: in FY98, there were six nursing homes identified with substandard in ("H" or higher level deficiencies – a pattern of actual harm); in FY99, there were 18. Although changes have occurred that have affected the number of complaints and the imposition of sanctions, the assessment of deficiencies by surveyors has remained unchanged. The increase in the number of homes with substandard quality of care clearly suggests a lowering of standards and care giving in Maryland's nursing homes.

Finding 3: Nursing Assistants, who provide most of the care in the homes, are in a position with little mobility, limited opportunity, and poor pay. The result is large turnover in these positions and continued staff shortages.

Estimates of the turnover rate of nursing assistants vary. The Washington Post in a recent article cites a national annual turnover figure of 93%. In testimony provided to the Nursing Practice/Quality of Care Workgroup on September 17, 1999, Sandra Martin, RN, a licensed nursing home administrator of Longview Nursing Home in Carroll County, provided insight into the staffing problems a typical home faces. The staff willing to work in her home are typically young persons dealing with socio-economic hardships. The home is limited in the wages it can pay due to the fact that 70% of the residents in Longview have their care financed by Medicaid. In an 18-month period, the home hired 159 employees; only 26 remained in their jobs at the end of the period. The nursing home loses staff to discount retail stores like Walmart, fast food chains and similar industries.

Ms. Martin identified several factors contributing to the problem: (1) there is no local training to create a labor pool, 2) the LPN program closed in Carroll County, and the Community College does not offer an affordable CNA or GNA program, and 3) there is no CNA trainee program offered by high schools or the YMCA to generate employees to do certain support tasks, such as help with bed-making, and providing socialization and "visiting" with the residents.

In this era of a booming economy, wages paid to nursing home workers cannot compete with other industries. A 1997 survey by the Hospital and Health Care Compensation Services found that nationally, CNAs in nursing homes earned an average of only $6.72 per hour. This is less than telemarketers ($9.19 per hour), photocopy machine operators ($9.46 per hour), or parking enforcement officers ($11.40 per hour).

The work of nursing assistants is hidden from most of society and is not sufficiently appreciated. It is also dangerous, due to potential injuries. The Service Employees International Union, in a recent position paper claimed that "Between 1984 and 1995 the illness and injury rate [among nursing home workers] increased from 11.6 to 18.2 per 100 full-time workers," a rate

higher than coal mining (6.2 per 100) or warehousing and trucking (13.8 per 100).

Finding 4: The Balanced Budget Act of 1997 reduced Federal reimbursement to nursing homes.

The Balanced Budget Act of 1997 sought to reform the system of Medicare reimbursement for a wide variety of services, including hospitals, home health agencies, and nursing homes. With respect to skilled nursing facilities, Congress enacted a prospective payment system. Previously, services in these facilities had been paid on the basis of costs, subject to certain limits. Under the new system, a methodology is used to develop a per diem payment based on grouping patients by their clinical characteristics.

Industry representatives and others claim that the new methodology does not take into account the costs of high acuity patients. Such patients need certain expensive services more than projected, such as respiratory therapy, lab tests, imaging services, and drugs. Procedures such as tracheotomies, care for pressure ulcers, dialysis, infusion therapy, and care associated with cancer, and congestive heart failure may not be fully accounted for in the methodology.

Most of the information on the impact of the new methodology has been anecdotal, but there has been acknowledgment by Federal officials that adjustments are needed. At a June 10, 1999 hearing before the Senate Finance Committee, Susan S. Bailis, representing the American Health Care Association stated that a survey conducted for her organization showed that since the enactment of the Act, "SNFs have experienced an average reduction in their daily Medicare payments of $50 per day per patient." The result has been that patients with more complex medical needs may be having difficulty gaining access to care.

In action on the FY 2000 Budget, Congress took measures to adjust the payment system and restore some of the Medicare cuts at least until more data can be gathered and analysis performed. While the impact of the Balanced Budget Act of 1997 on the nursing home industry in Maryland cannot be fully documented, it is clear that it has contributed to the quality of care problems being experienced by the industry in this state.

Finding 5: The 1998 Federal Nursing Home Initiatives (NHIs) have had a major resource impact on Maryland's regulatory system. This impact is compounded by OHCQ difficulty in recruiting qualified survey staff.

On July 21, 1998, President Clinton announced initiatives to improve regulatory oversight of nursing homes. The initiatives included a number of requirements, set by HCFA, to make changes in the way State licensing and survey agencies interacted with nursing homes. Among the changes:

Staggering survey times: In an effort to make nursing home inspections less predictable, States were directed to stagger survey times and conduct some surveys on weekends and in the evenings.

Targeting chains with bad records: State officials were to inspect more frequently those nursing homes that were part of chains with a poor record of compliance with quality standards.

Increased State oversight: HCFA was to increase oversight of state enforcement officials to insure they did not lift sanctions on homes until an on-site visit had confirmed compliance.

Specific Deficiencies: HCFA directed State surveyors to specifically monitor nursing home actions to prevent bed sores, dehydration, and malnutrition and to sanction nursing homes with patterns of violations.

More recently, HCFA has added to the new requirements by revising its directive to the States concerning complaint investigations. Complaints alleging actual harm must be ***initiated within 10 days,*** but not necessarily completed within this time frame.

The Nursing Home Initiatives required the states to allocate their staff resources differently. In FY98, Maryland, through the OHCQ, was able to successfully complete all of its federal survey requirements. In this fiscal year, in contrast, OHCQ expects to fall short of its federal survey requirement. The reason for this change is that the NHIs required the State to place more of a priority on follow-up surveys and complaint investigation, leaving less time for annual or "full" surveys.

It is not clear whether HCFA will also provide sufficient resources to fund implementation of federally mandated requirements. As of December 1, 1999, HCFA had not notified Maryland of its funding allocation for work that must be completed by September 30, 2000.

The State, however, has moved to expand support for OHCQ. The Governor and the General Assembly responded to OHCQ's lack of resources by authorizing an additional 18 surveyors for the fiscal year beginning July 1, 1999. Unfortunately, the Office has found recruiting difficult for these positions, due to poor salaries and working conditions.

Finding 6: In response to the GAO report and new directives from HCFA, OHCQ has made complaint investigation a higher priority.

As noted previously, the March 22, 1999 GAO report criticized Maryland for delays in responding to complaints of substandard care in nursing homes. Immediately prior to release of the GAO report, HCFA changed its directive to the states and required all allegations of actual harm to be investigated within 10 days.

In response to HCFA's directive and the GAO Report, OHCQ reorganized its operations to both reduce the backlog of complaints and implement the new policy. The result has been much more timely investigations of complaints as well as increased identification of deficient practices. Approximately one out of five complaints results in a "G" level or Actual Harm deficiency. The number of increased complaint investigations has also resulted in an increased frequency of "surprise" surveys. In FY99, OHQA received 1,013 complaints and conducted 556 complaint investigations. Frequency of nursing home visits in FY98 was approximately 1.6 per home; in FY99, it was 2.5.

The following chart demonstrated the increase in the number of nursing home complaints received and investigated:

	FY98	FY99	FY00 (projected)
No. Complaints Received	643	1013	*1896
No. Complaints Investigated	167	556	*1548

* Projections based on FY99 1st quarter data of 474 complaints and 387 complaint investigations.

Finding 7: State licensure laws for enforcing action against nursing homes with poor quality of care are not effective. These laws do not lead to early intervention and the encouragement of nursing homes to achieve and maintain compliance with standards. At present, enforcement action for nursing homes with poor quality is dependent on federal regulations.

Currently, Maryland is dependent on the federal system for enforcement action against nursing homes with serious deficiencies. Some of the problems with current State law are as follows:

- **Maryland's Civil Money Penalty statute is ineffective and unuseable.** A home must have a pattern of deficiencies over an extended period of time before the Office of Health Care Quality may impose a penalty. In addition, currently, when the Office notifies a facility that it is liable for a penalty, the facility is allowed the opportunity to correct the problem before the penalty is imposed. Most facilities report back the next day that they have corrected the problem; the Office then has only 24 hours to confirm this. If the Office could levy a penalty as soon as the deficiency is discovered, to continue until correction is verified, its enforcement of quality standards would be greatly strengthened.
- **Nursing homes can challenge the State's ability to impose a directed plan of correction.** For example, when the State has imposed a mandated staffing pattern because of certain deficiencies, nursing homes have chosen to appeal the action. The appeal stays the action and the directed plan of correction is not implemented
- **Maryland does not have an effective mechanism for appointing third parties to oversee facilities.** Other states have found that use of "State-Appointed Monitors" has been an effective tool to monitor corrective action in a troubled facility. Although Maryland has a receivorship law, appointment of a receivor is cumbersome.
- **The State does not have the ability to deny a license to a new owner or manager if the owner or manager has a track record of poor performance, either in Maryland or in**

another state.

- **Current law does not allow DHMH to take a more positive approach with facilities which are willing to cooperate.** In some cases, the Office of Health Care Quality could make more progress in improving care if it could work cooperatively with facilities, providing technical assistance and consultation, rather than always being in the position of being a long term care enforcer. Maryland's lack of an effective Civil money penalty contributes to this problem, because the State does not have a penalty fund which can be used to finance innovation. Since penalties which are collected are done so under federal guidelines, the State must obtain approval to use these funds. This year, OHCQ applied to use the funds to conduct a study to determine the effects of relocation trauma and also to fund a project to encourage and assist with the development of family councils. Access to the funds was questioned and delayed. If the State had an effective fining mechanism, funds could be used for training, grants for projects such as the Eden Alternative and other quality initiatives.

Finding 8: Maryland nursing homes are not practicing internal health quality assurance and as a result are less proactive in dealing with quality issues.

Federal law requires each nursing home to have a quality assurance program capable of problem identification and corrective action. However, administration of these programs is frequently delegated to the Director of Nursing. OHCQ reports that Quality Assurance Programs vary across the State and in many homes, are nonexistent. In these cases, the State, through the survey process, acts as the nursing facility's internal Quality Assurance Program. In addition, medical oversight in nursing facilities is weak. The role and responsibility of the medical director are unclear.

The lack of health quality assurance programs in the industry results in a number of systemic problems which ultimately give rise to poor care. These systems problems manifest themselves in several ways:

Failure to follow recognized protocols. According to Steven Levenson, MD, president of the Maryland Medical Directors Association (MMDA), his association has identified desirable health outcomes for residents, and standards of care protocols for medical conditions have been published. The problem is that these accepted protocols are not followed consistently from one facility to another. Physicians need to be held accountable when there are lapses in care or protocols are not followed.

Lack of standards for nurses in long term care. According to Dr. Ann Marie Spellbring, there are recognized codes of conduct/ethics for nurses but, at present, no accepted definitions of the essential responsibilities of nurses in long term care. The Long Term Care Coalition Task Force, convened by the Maryland Board of Nursing and composed of representatives from the Maryland Nurses Association, the Maryland Medical Directors Association and nurses representing the long term care industry, is in the process of drafting documents which will provide these definitions, but at present they do not exist.

Absence of Continuous Quality Improvement Programs. While these programs are now standard throughout the health care industry, they are less visible in nursing homes.

Finding 9: Advocacy efforts on behalf of nursing home residents are underfunded and need to be strengthened. In particular, the Long Term Care Ombudsman program does not have the resources to do its job.

The Long Term Care Ombudsman Program is authorized by the federal Older Americans Act and Article 70B of the State Code. Its purpose is to provide advocacy for long term care residents, primarily focusing on complaint resolution activities. Since its inception, the scope and responsibilities of the program have expanded to include the use of volunteers, service to assisted living facilities and working with family/resident councils. The Maryland Ombudsman Program consists of one State Ombudsman and 19 local programs operated by Area Agencies on Aging.

Each year, the Ombudsman program investigates more than 2,000 complaints in Maryland's long term care facilities. These complaints range from relatively minor issues such as complaints about food to allegations of abuse and criminal activity. Often, the Ombudsman is able to serve as a mediator to help resolve differences between families and nursing home staff. In addition, the Ombudsman frequently is able to make the nursing home administrator aware of problems which have not come to his or her attention. When necessary, the Ombudsman makes referrals to the Office of Health Care Quality or law enforcement.

The Ombudsman program has received strong support from the industry, advocates and regulators alike. In Fiscal Year 2000, this support enabled the Department to budget State funds for support of the program, as part of the Vulnerable Elderly Program Initiative. Despite this, however, the Ombudsman program is not sufficiently funded to provide consistent advocacy for residents across the State. There are 29 Long Term Care Ombudsman staff in Maryland. As of October 1, 1999, only 11 of these individuals were performing Ombudsman duties full time. The rest combine Ombudsman duties with other responsibilities such as public guardianship or assisted living program management. Eighty-nine volunteer Ombudsmen assist the program in six of Maryland's jurisdictions (Anne Arundel, Baltimore, Carroll, Montgomery, Prince George's Counties and Baltimore City). Volunteers, however, are not "free"; for a volunteer program to operate effectively, it needs supervision, training, backup, and recognition.

Reports from local Maryland Ombudsmen indicate that because of the increases in the complexity and nature of the problems to which the program is responding, only 83% of nursing homes in MD are monitored regularly by the Ombudsman; the rest of the facilities are visited only in response to complaints. The Ombudsmen report that they do not have time to: 1) recruit, train and supervise volunteers, 2) conduct in service training for nursing home staff, 3) work with resident/family councils, 4) accompany surveyors on site visits, 5) establish rapport with residents/families and 6) improve the response time to complaints.

As of 1999, there are more than 45,000 nursing home and assisted living beds in Maryland. The Department of Aging recommends a minimum staff to resident ratio of one full time Ombudsman for every 1,000 beds. To meet this ratio, the number of full-time Ombudsmen would have to increase to 45 full-time equivalents. A significant increase in funding will be needed if the

Department is to achieve this goal.

Finding 10: Family Councils can be a valuable source of advocacy for residents, provided that they operate independently of nursing home administration.

Family councils consist of relatives of nursing home residents, and have existed since the late 1970's. Councils provide a positive way for families to be involved in the care of residents, and to assure that mandated standards are being met. In some states, particularly Minnesota and North Carolina, strong family councils have had important impacts on quality of care and advocacy efforts.

Two family councils submitted testimony to the Task Force: the Family Council for HCR~Manor Care Chevy Case, and Families for Better Nursing Home Care (the council for the Westminster Nursing and Rehabilitation Center). A draft brochure submitted by Families for Better Nursing Home Care summarizes the activities of the group. The group meets periodically to discuss nursing home issues, conducts surveys based on family concerns about care, meets with staff of the nursing home to discuss concerns, compiles "best practices" from other facilities, acts as a liaison with other family councils, works with staff to establish processes for families to monitor care, establishes a process for families to report incidents, and consults with the local Ombudsman.

Most nursing homes in Maryland do not have family councils. There are a number of barriers to their implementation, ranging from lack of support from facilities, ombudsmen, or families themselves to interference by administrators or fear of retaliation by family members. A strong network of family councils in Maryland would go a long way toward breaking down the isolation experienced by residents and their families, and creating momentum for large scale improvements in care.

SECTION 6 RECOMMENDATIONS

Based on the findings, the Task Force is making six major recommendations. The major recommendations are listed below. A more detailed presentation of the recommendations, with various sub recommendations agreed upon by the Task Force, is set forth on the pages following.

Recommendation #1 **Continue the Task Force as an oversight committee to monitor progress on the implementation of its recommendations**. This recommendation will require legislation. Fiscal impact will be minimal.

Recommendation #2 **Increase minimum staffing standards for resident care in nursing homes, to four hours per resident per day, with unlicensed direct care staffing set at a minimum of three hours per resident per day.** This recommendation will require legislation.

The estimated cost to the Medicaid Program is $70.1 million per annum. Contained within this recommendation are sub-recommendations designed to increase both professional and direct care staffing in nursing homes. A key sub recommendation is to establish a Medicaid financed wage-pass through, designed to increases nurse aide hourly wages by $2.00 per hour. Estimated cost to the Medicaid program: $28.5 million (See Appendix A).

Recommendation #3 Improve the quality of the nursing home workforce. This recommendation contains a number of strategies designed to improve the nursing home workforce, retain qualified workers, create career ladders, and to promote ongoing training.

Recommendation #4 Strengthen State regulation of nursing homes. This series of recommendations is designed to provide the Department of Health and Mental Hygiene with greater ability to inspect nursing homes, impose penalties when necessary, and to provide families and residents with more information about the quality of nursing homes. The recommendation includes proposals to ease the Office of Health Care Quality's staffing problems.

Recommendation #5 Improve quality assurance programs in nursing homes. This recommendation mandates a series of initiatives designed to improve quality of medical care, enhance efficiency, and exert more accountability on medical professionals in nursing home settings.

Recommendation #6 Strengthen consumer advocacy, including the long term care ombudsman program. This recommendation requires the State to provide more support for advocates for residents of long term care facilities, in particular the long term care ombudsman program. It includes funding the Ombudsman program at a ratio of one FTE per 1,000 long term care beds (including Assisted living beds). Estimated cost in State general funds: $1.9 million. (See Appendix B).

Recommendation No.	Recommendation	Lead Agency	Nature of Action	Impact on State Budget
1	**General Recommendation on Continuation of the Task Force (All Findings)**			
1.1	Continue the Task Force as an oversight committee to monitor progress on the implementation of its recommendations	MDoA	Legislation	minimal
1.2	Require OHCQ to report to the oversight committee twice annually on the progress and status of quality of care.	DHMH	Legislation	
1.3	Support the Maryland Health Care Commission's effort to develop a report card to compare nursing home performance.	DHMH and MDoA	Policy	
2	**Recommendations on Staffing in Nursing Homes (Findings 1 and 2)**			
2.1	Increase the staffing minimum standard to 4 hours per resident per day. The nursing homes would have 18 months to achieve this standard.	DHMH	Legislation	Yes
2.2	Increase non-licensed direct care staff to 3 hours per resident per day.	DHMH	Legislation	Yes

Recommendation No.	Recommendation	Lead Agency	Nature of Action	Impact on State Budget
2.3	Increase Medicaid reimbursement for direct care and allow Medicaid reimbursement for training.	DHMH	Legislation	Yes
2.4	Institute wage pass through for CNAs.	DHMH	Legislation	Yes
2.5	Strengthen DHMH regulations to allow the Department to set staffing ratios above the minimum standard when needed to meet increased resident acuity.	DHMH	Legislation	Yes
2.6	Require nursing homes to post staffing on each unit for each shift in an area visible to residents, family and visitors.	DHMH	Legislation	
3	**Improve the quality of the nursing home workforce (Findings 3 and 8).**			
3.1	Establish a coalition of stakeholders to study nursing and nursing assistant shortages and to make recommendations on recruitment and retention.	DHMH, MDoA , DLLR, Workforce Investment Board	Policy	

Recommendation No.	Recommendation	Lead Agency	Nature of Action	Impact on State Budget
3.2	Promote internships and scholarships for students entering long term care nursing.	DHMH, MDoA, University system	Policy	
3.3	Seek cooperation from the Board of Nursing in the development of pilot programs establishing career ladders for nursing assistants.	DHMH, MDoA	Policy	
3.4	Require nursing schools to include a practicuum in long term care as part of their curricula.	Board of Nursing	Regulation	
3.5	Require community colleges in Maryland to offer training for nursing assistants.	Maryland Higher Education Commission	Legislation	
3.6	Require nursing homes to provide in-service training to all staff in dementia care.	DHMH	Regulation	
3.7	Require nursing homes to provide in-service training to all staff on abuse prevention.	DHMH	Regulation	
3.8	Require nursing homes to increase the number of hours of in-service training offered to nursing assistants.	DHMH	Regulation	

Recommendation No.	Recommendation	Lead Agency	Nature of Action	Impact on State Budget
3.9	Encourage nursing homes to establish mentoring programs for nursing assistants, possibly funded by civil money penalty fund.	DHMH	Policy	
3.10	Encourage nursing home industry to convert vacant bed space to child daycare centers as a benefit to attract and retain nursing staff. Such action would not affect the facility's licensed bed capacity.	DHMH, MdoA	Policy	
4	**Strengthen State Regulation of nursing homes (Findings 6 and 7).**			
4.1	Insure sufficient OHCQ staff to do annual surveys and complaint investigations.	DHMH	Budget	Yes
4.2	Encourage DHMH to hire surveyors with long term care experience.	DHMH	Policy, Budget	
4.3	Upgrade the OHCQ surveyor classification and ease recruitment process.	DHMH	Policy, Budget	Yes
4.4	Give DHMH the authority to mandate a plan of correction and to dictate staffing patterns pending appeal for homes with a record of deficiencies.	DHMH	Legislation	

Recommendation No.	Recommendation	Lead Agency	Nature of Action	Impact on State Budget
4.5	Publicly disclose all survey reports within 30 days of completion of surveys. Make notice of violations available for publication, distribute complaint and deficiency reports to local Health Offices, Area Agencies on Aging, and the press.	DHMH	Policy	
4.6	Require nursing homes to notify families members, guardians, and residents when the facility receives first notification by OHCQ that it is in danger of closure.	DHMH	Legislation	
4.7	Require more stringent criteria for the acceptance of a facility plan of correction.	DHMH	Regulation	
4.8	Allow DHMH to write regulations to require a minimum time period between surveys to ensure sustained corrective action.	DHMH	Legislation	
4.9	Require that OHCQ conduct a minimum of 4 visits per year at each nursing home and further that the surveys be unannounced visits.	DHMH	Legislation	Yes
4.10	Revise civil money penalty to allow more effective use of fines.	DHMH	Legislation	

Recommendation No.	Recommendation	Lead Agency	Nature of Action	Impact on State Budget
4.11	Impose immediate fines for certain types of deficiencies.	DHMH	Legislation	
4.12	Allow DHMH the authority to set up a special fund financed by civil money penalties to improve quality of care in nursing homes.	DHMH	Legislative	No additional General funds required
4.13	Allow the use of state-appointed monitors to evaluate homes with certain types of deficiencies.	DHMH	Legislation	
4.14	Allow DHMH to develop regulations that set forth the specific financial and performance data the applicant must submit in order to be approved for a nursing home license. The OHCQ should review this information on a timely basis.	DHMH	Legislation	
4.15	Require nursing homes to give residents/families/guardians at least 7 days notice of quarterly care planning conferences.	DHMH	Regulation	
5	**Improve quality assurance programs in nursing homes (Finding 8).**			

Recommendation No.	Recommendation	Lead Agency	Nature of Action	Impact on State Budget
5.1	Define the role of medical director and generally provide for medical staff accountability.	DHMH	Legislation	
5.2	Require Medical schools in Maryland to include clinical geriatrics in their curricula.	State Higher Education Commission determined	Lesgislation	
5.3	Phase in a requirement that medical directors in nursing homes have geriatric training.	DHMH	Regulation	
5.4	Support automation of paperwork and charting through partial reimbursement for automation systems approved by DHMH.	DHMH	Legislation	
5.5	Require each nursing home to employ a dedicated quality assurance professional to manage and monitor quality assurance.	DHMH	Legislation	No
5.6	Require DHMH to create a technical assistance unit to support compliance efforts and best practices.	DHMH	Legislation	

Recommendation No.	Recommendation	Lead Agency	Nature of Action	Impact on State Budget
5.7	Require the Board of Nursing Home Administrators to mandate in-service training every two years for nursing home administrators to cover requirements of Federal and State nursing home regulatory laws. Attendance at this training would be a condition for licensure.	DHMH	Legislation	
6	**Consumer Advocacy Including Ombudsman Program (Findings 9 and 10)**			
6.1	Establish and fund minimum staffing ratios for Ombudsman Program at the higher of a) One FTE Ombudsman per 1,000 long term care beds or: b) 20 hours Ombudman time per week per Area Agency on Aging or c) 10 hours Ombudsman time per week per nursing home.	MDoA	Budget,Legislation	Yes
6.2	Promote use of ombudsman volunteers, friendly visitors, and consumer advocates.	MDoA	Policy	

Recommendation No.	Recommendation	Lead Agency	Nature of Action	Impact on State Budget
6.3	Require Department of Aging to develop a checklist for residents and families to assess resident care.	MDoA	Policy	
6.4	Allow ombudsman to advocate for confused residents without surrogates in non-abuse matters.	MDoA	Legislation	
6.5	Strongly encourage nursing homes to establish family councils led by residents and volunteers.	DHMH, MDoA	Policy	
6.6	Require the OHCQ to develop standards for the operation of family councils. Require the OHCQ to report to the nursing home oversight committee about the success of family councils.	DHMH	Legislation	

APPENDIX A

COST ANALYSIS:

I Establish a minimum standard of 3.0 hours of care per patient day of Aide time - Nurse Aides and certified Medication Aides and

Establish a minimum standard of 4.0 total hours of care per patient day

(Prepared by the Maryland Department of Health and Mental Hygiene)

BACKGROUND:

Based on the recent recalibration of nursing hours, effective 10/1/99, and the average statewide acuity, the Medicaid Program reimburses, on average, for 3.20 hours of care per patient day. A more detailed analysis indicates that 2.23 hours of this care (69.7%) is provided by nurse aides and certified medication aides and .97 hours (30.3%) is provided by licensed practical nurses and registered nurses.

ANALYSIS:

Raising the minimum nurse aide/certified medication aide time to 3.0 hours of care per patient day would require an increase of .77 hours in per diem aide time. However, to meet this objective **and** the objective of 4.0 total hours of care per day, providers, on average, would be required to increase nurse aide hours by .80 hours. Based on the statewide adjusted nurse aide wage of $11.75, the increase in nursing reimbursement per day would be $9.40 and when multiplied by 6.2 million Medicaid days would result in an increase of $58.3 million.

Since nursing home providers would be mandated to staff at this higher level, nearly all of the anticipated recovery in the nursing cost center of $2.10 per patient day would be eliminated. Assuming the lost would be $1.90 per patient day, i.e., recovery is reduced to $.20 per patient day, the total lost in recovery ($1.90 times 6.2 million days) would be $11.8 million. This loss in recovery would bring the cost of these two changes to $70.1 million.

II Increase Nurse Aides and Certified Medication Aides Salaries by $2.00 per hour.

ANALYSIS:

Giving a wage raise of $2.00 per hour to each nurse aide and certified medication aide would increase average nursing reimbursement by $4.59 per patient day at current staffing. When multiplied by 6.2 million days the cost would be $28.5 million. This change alone would also eliminate most of the anticipated recovery of $2.10 per patient day.

If this wage increase occurs in conjunction with the increased staffing described above, the cost would be $15.59 per patient day, which accounts for the fact that the .80 hours of added nurse aide time would also be reimbursed at the higher salary. When multiplied by 6.2 million days, the increased cost is $96.7 million. This computation does not account for the increase in fringe benefits as a result of higher hourly wages paid for sick and vacation leave.

If this change were to occur, the proposed loss in nursing recovery is projected to be $2.00 per patient day and when multiplied by 6.2 million days adds an added cost of $12.4 million to these changes, for a total of $109.1 million.

APPENDIX B

Cost of Implementing Recommendation 6.1: Minimum Staffing Ratios for the Long Term Care Ombudsman Program *(prepared by the Maryland Department of Aging)*

Implementation of Recommendation 6.1 will require an additional $1,900,847 in State funds.

The recommendation proposes a formula which establishes a ratio of either one full-time equivalent Ombudsman per 1,000 long term care beds, 20 hours Ombudsman time per week per Area Agency on Aging or 10 hours Ombudsman time per week per nursing home, whichever of the three yields the highest allocation for a given Area Agency on Aging.

The calculations below are based on the following data and assumptions:

1) There are 30,861 nursing home beds and 14, 672 assisted living beds in Maryland for a total of 45,533 long term care beds in Maryland. (Maryland Department of Health and Mental Hygiene, Office of Health Care Quality, 1999).

2) There are 261 nursing homes in Maryland ((Maryland Department of Health and Mental Hygiene, Office of Health Care Quality, 1999).

3) Projected average cost of one Ombudsman Full-Time-Equivalent, Salary and Fringe= $37,500. Hourly rate (assuming 40 hours per week)= $18.03 per hour.

4) FY 2000 Federal and State funding for the Ombudsman program in Maryland= $546,185

Calculation 1: One full-time equivalent Ombudsman per 1,000 long term care beds:

45,533 LTC beds / 1000 beds	=45.533 FTE Ombudsman*37,500 per FTE=	$1,707,488
	Less Current Ombudsman Funding =	$ 546,185
	Increase in Funding Required to meet ratio=	**$1,161,303**

Calculation 2: Ten Hours Ombudsman time per week per nursing home:

261 nursing homes* 10 Ombudsman hrs per wk. per nursing home*52=	135,720 hrs*$18.03 per hr =	$2,447,032
	Less Current Ombudsman Funding =	$ 546,185
	Increase in Funding Required to meet ratio=	**$1,900,847**

Analysis of the distribution of nursing homes in the local jurisdiction shows that the third part of the formula (a minimum of 20 hours Ombudsman time per Area Agency on Aging) would be covered by the allocation resulting from Calculation 2.

APPENDIX C

Workgroup on Consumer Protection & Patient Rights

Name	Affiliation
Chair: William Bechill	Maryland Commission on Aging
University of Maryland School of Social Work	
Ernest B. Crofoot	United Seniors of Maryland
Tammy Hagin - Baltimore City Commission on Aging and Retirement Education	Long Term Care Ombudsman
Peggy Leonard - Genesis Multi-Medical	Health Facilities Association of Maryland
Bobette Watts	Governor's Office for Individuals With Disabilities
L.E. "Bud" Zimmerman - Charles County Nursing and Rehabilitation Center	Mid-Atlantic Non-Profit Health and Housing Association
Marsha Ansel - Springfield Hospital Center	National Association of Social Workers
Marie Ickrath - Baltimore Mental Health Systems, Inc.	Mental Health Association
Nancy Caliman	National Caucus & Center on the Black Aged
Susan Shubin - Legal Aid Bureau Nursing Home Program	Maryland State Bar Association
Larry Ginsberg	Service Employees International Union1199 E
Martha Mohler	National Committee to Preserve Social Security & Medicare
Staff:	
Mike Lachance	*Department of Aging*
Carol Benner	*Office of Health Care Quality, Department of Health & Mental Hygiene*

APPENDIX D

Nursing Practice/Quality of Care Workgroup

Name	Affiliation
Chair: Ann Marie Spellbring, PhD	University of Maryland School of Nursing
Marjorie Richmond - Anne Arundel County Department of Aging	Long Term Care Ombudsman
Bea Rodgers	Governor's Office for Individuals with Disabilities
Madeline Turkeltaub	Maryland Nurses Association
Glenn Scherer - Augsburg Lutheran Nursing Home	Mid-Atlantic Non-Profit Health and Housing Association
Michelle Bellantoni -Johns Hopkins Geriatric Center	Geriatrician
Barbara Kimsey - Stella Maris	Health Facilities Association of Maryland
Larry Ginsburg	Service Employees International Union 1199 E
Donna Deleno	Alzheimer's Association
Margaret Richards - Johns Hopkins Geriatric Center	Maryland Hospital Association
Mary Edwards	National Citizens Coalition for Nursing Home Reform
Gail MacInnes, National Citizens Coalition for Nursing Home Reform	Family member
Narcissus Jackson - Keswick Multi-Care Center	Certified Nursing Assistant, Union
Deirdre Coleman - Charlestown Retirement Community	Certified Nursing Assistant, Non-union
Staff:	
Stephanie Garrity	*Department of Aging*
Carol Benner	*Office of Health Care Quality, Department of Health and Mental Hygiene*